

Maryland Board of Occupational Therapy Practice
Spring Grove Hospital • 55 Wade Avenue • Bland Bryant Building, 4th Floor • Baltimore, MD 21228
Phone: 410-402-8560 • Fax: 410-402-8561 • www.dhmfh.maryland.gov/botp
Application for License Renewal

RENEWAL DEADLINE: MAY 31, 2012 (POSTMARKED)	SOCIAL SECURITY NUMBER: _____ - _____ - _____ I attest to earning the required continuing education credits indicated below: (check one) <input type="checkbox"/> 12 hours: licensed >1 year (licensed prior to 7/1/2011) <input type="checkbox"/> 0 hours: licensed < 1 year (licensed after 7/1/2011) Home Phone: (____) _____ Work Phone: (____) _____ Email address: _____															
<table border="1" style="width: 100%; border-collapse: collapse;"><thead><tr><th style="width: 60%;">Fees (Make checks payable to: MD Board of OT)</th><th style="width: 15%;">Total Due</th><th style="width: 25%;">Amount Enclosed</th></tr></thead><tbody><tr><td>1. OT – Occupational Therapist – includes \$100 Renewal Fee + \$13 MHCC Fee</td><td style="text-align: center;">\$113</td><td>_____</td></tr><tr><td>2. OTA – Occupational Therapy Assistant</td><td style="text-align: center;">\$ 80</td><td>_____</td></tr><tr><td>3. Elective Non-Renewal Status (Inactive)</td><td style="text-align: center;">\$ 25</td><td>_____</td></tr><tr><td>4. Renewal Late Fee - \$25 for renewal applications postmarked between 6/1 and 6/30</td><td style="text-align: center;">\$ 25</td><td>_____</td></tr></tbody></table>		Fees (Make checks payable to: MD Board of OT)	Total Due	Amount Enclosed	1. OT – Occupational Therapist – includes \$100 Renewal Fee + \$13 MHCC Fee	\$113	_____	2. OTA – Occupational Therapy Assistant	\$ 80	_____	3. Elective Non-Renewal Status (Inactive)	\$ 25	_____	4. Renewal Late Fee - \$25 for renewal applications postmarked between 6/1 and 6/30	\$ 25	_____
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Write YES or NO for the following, since your last renewal: ____ 1. During the last year, have you been addicted to drugs or alcohol? ____ 2. During the last year, has any state licensing or disciplinary board, or a comparable body in the armed services, denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation? ____ (b) During the last year, have you surrendered a license in any jurisdiction due to disciplinary proceedings? ____ 3. During the last year, are there any outstanding complaints, investigations or charges pending against you in any jurisdiction (including Maryland) by any licensing or disciplinary board or a comparable body in the armed services? ____ 4. During the last year, have you had a physical, or mental illness that currently impairs your ability to practice your profession? ____ 5. During the last year, have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment for any criminal act?	____ 6. During the last year, have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense? ____ 7. During the last year, has any hospital or related healthcare institution or employer denied you privileges or employment, denied any application or contract or limited, restricted, suspended, revoked, or terminated your privileges or employment contract for any reason related to your practice? ____ 8. During the last year, have the conditions of your employment been affected by any termination of employment, suspension, or probation for any reason related to your practice? ____ 9. During the last year, has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you? ____ 10. During the last year, have you knowingly practiced occupational therapy in the State of Maryland or any other jurisdiction without an active license? <small>If YES is answered to any question, attach a detailed explanation for each question answered yes and include a certified copy of court records, if applicable.</small>															
Health Occupations Article §1-202 requires that you verify that you are complying with the Worker's Compensation Law for your renewal to be issued. I hereby certify: (a) <input type="checkbox"/> I do practice in Maryland, but I do not employ anyone in my practice, <u>OR</u> (b) <input type="checkbox"/> I do not practice in Maryland, <u>OR</u> (c) <input type="checkbox"/> I practice in Maryland, and employ one or more persons in my practice and will maintain Workmen's Compensation coverage continuously throughout the license renewal period. If YES to (c), complete insurance information below. Insurance Company: _____ Policy Number: _____ Expiration Date: _____																
Notice for Mailing List <small>The information collected on the license application form and the license renewal forms is collected for the purposes of the Board's functions under the Maryland Health Occupations Code Annotated, Title 10. Failure to provide the information may result in the denial of your application for an initial or renewed license. You have a right to inspect, amend, and correct this information. The Board may permit inspection of this information, or make it available to others, only as permitted by federal and State law. The Board may sell or provide a list of licensees' names and addresses to professional associations and other entities. Under the Maryland Public Information Act, Maryland State Government Code Annotated 10-617, you may request in writing that your name be omitted from such lists.</small>																
Area of Practice/Specialty: Please check one: 1. <input type="checkbox"/> Mental Health 2. <input type="checkbox"/> Productive Aging 3. <input type="checkbox"/> Children and Youth 4. <input type="checkbox"/> Work and Industry 5. <input type="checkbox"/> Rehab, Disability & Participation 6. <input type="checkbox"/> Other 7. <input type="checkbox"/> None	Race/Ethnicity: Voluntarily please check <u>all</u> that apply: 1. <input type="checkbox"/> American Indian or Alaska Native 2. <input type="checkbox"/> Asian 3. <input type="checkbox"/> Black or African American 4. <input type="checkbox"/> Hispanic or Latino 5. <input type="checkbox"/> Native Hawaiian or other Pacific Islander 6. <input type="checkbox"/> White 7. <input type="checkbox"/> Other															
Complete If Name Changed. Include Copy Of Legal Document. Last Name & Generational Indicator (Jr., III, Etc.): _____ First Name & Middle Name/Initial: _____ Complete If Address Changed. Address: _____ City: _____ State: _____ Zip Code: _____	Practice of occupational therapy without an active license is a violation of the Occupational Therapy Practice Act. I affirm that the content of this document is true and correct to the best of my knowledge and belief. Signature: _____ Date: _____ License Number: _____															
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